Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

# General

## Guideline Title

Bone marrow synoptic reporting for hematologic neoplasms: guideline from the College of American Pathologists Pathology and Laboratory Quality Center.

## Bibliographic Source(s)

Sever C, Abbott CL, de Baca ME, Khoury JD, Perkins SL, Reichard KK, Taylor A, Terebelo HR, Colasacco C, Rumble RB, Thomas NE. Bone marrow synoptic reporting for hematologic neoplasms: guideline from the College of American Pathologists Pathology and Laboratory Quality Center. Arch Pathol Lab Med. 2016 Sep;140(9):932-49. [76 references] PubMed

## Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

# Recommendations

## Major Recommendations

The grades for strength of recommendations (Strong recommendation, Recommendation, Expert consensus opinion, No recommendation) are defined at the end of the "Major Recommendations" field.

Guideline Statements

1. Laboratories should adopt synoptic reporting as a component of bone marrow pathology reports for clearly defined neoplasia or widely applied classification schemes and receive appropriate institutional support. (Strong recommendation)
2. When reporting on peripheral blood specimens for bone marrow synoptic reports, laboratories should report clinically and diagnostically pertinent elements, if available. These key elements may include one or more parameters from complete blood cell count, absolute cell counts, and relevant morphologic descriptors. (Strong recommendation)
3. When reporting bone marrow aspirate results, laboratories should report clinically and diagnostically pertinent elements in the synoptic section. These key elements may include the evidence-based parameters, such as blast percentage, dysplasia, myeloid to erythroid ratio, morphology of myeloid/lymphoid elements, and enumeration of lymphoid elements and plasma cells; additional elements may be included in nonsynoptic sections of the report. (Strong recommendation for blast percentage; Recommendation for all other parameters)
4. When reporting bone marrow core biopsy results, laboratories should report clinically or diagnostically pertinent elements in the synoptic section. These key elements may include the evidence-based parameters, such as fibrosis, cellularity, distribution pattern of hematopoietic elements, morphology of lymphoid elements, and enumeration of lymphoid elements and plasma cells; additional elements may be included in the nonsynoptic sections of the report. (Strong recommendation for fibrosis; Recommendation for all other parameters)

5. If relevant ancillary testing studies are performed on the primary sample (blood or bone marrow), laboratories should report the results, general methodology, performance site, and interpretation site or have the data readily available. If the results are not available, pending status should be stated explicitly. (Strong recommendation)
6. Laboratories should include in the synoptic section of the report data groups for diagnosis, supporting studies, and ancillary data that are critical for diagnosis. Key morphologic descriptors should be included and may be in the diagnosis line if they are critical or a component of the disease classification. The diagnosis (or diagnosis group) should head the synoptic section when possible. A narrative, interpretative comment should immediately follow the synoptic section if required. (Strong recommendation for inclusion of data groups for diagnosis, supporting studies, and ancillary data; Recommendation for the layout of the data groups)
7. Laboratories should consider the integrity of electronic data transmission for formatting and data presentation of synoptic reports. (Strong recommendation)
8. No recommendation was made regarding the inclusion of coding terms in a synoptic report because coding terms are distinct from scientific terms and vary considerably among health authorities, payers, and different countries. (No recommendation)
9. Laboratories should include clinical and laboratory data required for a definitive diagnosis in the synoptic section, along with its source(s), if applicable. (Recommendation)

Definitions

Grades for Strength of Recommendations*

| Designation | Recommendation | Rationale |
|---|---|---|
| Strong Recommendation | Recommend for or against a particular bone marrow synoptic reporting practice (can include must or should) | Supported by convincing (high) or adequate (intermediate) quality of evidence and clear benefit that outweighs any harms |
| Recommendation | Recommend for or against a particular bone marrow synoptic reporting practice (can include should or may) | Some limitations in quality of evidence (adequate[intermediate] or inadequate [low]), balance of benefits and harms, values, or costs, but panel concludes that there is sufficient evidence and/or benefit to inform a recommendation |
| Expert Consensus Opinion | Recommend for or against a particular bone marrow synoptic reporting practice (can include should or may) | Serious limitations in quality of evidence (inadequate[low] or insufficient), balance of benefits and harms, values, or costs, but panel consensus is that a statement is necessary |
| No Recommendation | No recommendation for or against a particular bone marrow synoptic reporting practice | Insufficient evidence or agreement of the balance of benefits and harms, values, or costs to provide a recommendation |

**Derived from*: Guyatt GH, Oxman AD, Vist GE, et al; GRADE Working Group. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. BMJ. 2008;336(7650):924–926.

## Clinical Algorithm(s)

None provided

# Scope

## Disease/Condition(s)

Hematological neoplasms

## Guideline Category

Diagnosis

Evaluation

## Clinical Specialty

Hematology

Oncology

Pathology

## Intended Users

Clinical Laboratory Personnel

Health Care Providers

Physician Assistants

Physicians

## Guideline Objective(s)

- To develop a series of evidence-based recommendations to standardize the basic components of a synoptic report template for bone marrow samples that would address the following domains: bone marrow morphologic descriptors, possible tests (by category) to be performed on the primary sample, relevant clinical and laboratory information, necessary components (regulatory, legal, financial, among others), and layout
- To address the following key questions:
    1. Considering the possible primary bone marrow morphologic descriptors, which ones are required on a synoptic report if completeness is the outcome of interest?
    2. Considering the possible ancillary studies that could be ordered on a bone marrow specimen, which ones are required on a synoptic report if completeness is the outcome of interest?
    3. What sequence of results reporting should be followed?
        a. Considering the options available, is there an optimal report format that should be used if ease of use, error reduction, and fewer incompletes are the outcomes of interest
        b. Is there an optimal presentation for the elements of the minimum data set if the outcomes of interest are clarity and ease of use?
    4. Which components required for correct coding and data repositories should be included in the report?
        a. Coding
        b. Registries
        c. National guidelines (e.g., National Comprehensive Cancer Network
        d. Physician payment incentive requirements (e.g., Physician Quality Reporting System)
    5. What clinical or laboratory information should be included in the report?

## Target Population

Patients with hematological neoplasms requiring bone marrow pathology

## Interventions and Practices Considered

1. Adoption of synoptic reporting as a component of bone marrow pathology reports for clearly defined neoplasia
2. Key elements for inclusion in synoptic reports for peripheral blood specimens, bone marrow aspirates, and bone marrow core biopsy
3. Reporting of ancillary testing studies on blood or bone marrow
4. Inclusion of data groups for diagnosis, supporting studies, and ancillary data
5. Layout of the data groups

6. Consideration of the integrity of electronic data transmission for formatting and data presentation
7. Inclusion of coding terms in a synoptic report (considered but not recommended)
8. Inclusion of clinical and laboratory data required for a definitive diagnosis in the synoptic report, along with its sources

## Major Outcomes Considered

- Completeness of reporting systems
- Clarity and ease of use of reporting systems
- Error reduction
- Number of incomplete reports
- Relevance of clinical and laboratory information

# Methodology

## Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

## Description of Methods Used to Collect/Select the Evidence

Literature Search and Selection

The systematic literature review for relevant evidence included a search using both OvidSP (http://ovidsp.ovid.com, accessed November 30, 2012; Ovid Technologies, New York City, New York) and PubMed (http://www.ncbi.nlm.nih.gov, accessed December 5, 2012; National Library of Medicine, Bethesda, Maryland) for articles published from January 2002 through November 2012. Medical subject headings and key words were selected to capture the concepts of bone marrow samples, ancillary testing, pathology reporting, and benign and malignant hematologic diagnostic entities. The searches were limited to human studies published in English, and a publication filter was applied to exclude less rigorous study designs, as well as letters, commentaries, and editorials. A separate search for literature using PsycINFO (http://www.apa.org/pubs/databases/psycinfo, accessed November 26, 2012; American Psychological Association, Washington, DC) was completed to identify articles that addressed the concepts of reading comprehension, communication, and clarity. Database searches were supplemented by a search for grey literature using Cochrane Library (http://www.cochranelibrary.com, accessed January 3, 2013; Cochrane Collaboration, London, England), TRIP database (http://www.tripdatabase.com, accessed January 3, 2013; Trip Database Ltd, Newport, Wales), Grey Literature Report (http://www.greylit.org, accessed January 2, 2013; New York Academy of Medicine Library, New York), and Google Scholar (https://scholar.google.com, accessed January 2, 2013; Google, Mountain View, California), a review of relevant meeting abstracts (2011–2012), and a hand-search of selected relevant journals. A refresh of the Ovid and PsycINFO searches was completed (July 9, 2014) to capture studies published through June 2014. Detailed information regarding the literature search strategy can be found in the supplemental digital content (SDC) (see the "Availability of Companion Documents" field).

Inclusion Criteria

Published studies were selected for full text review if they met each of the following criteria:

1. Human studies
2. Original research addressing bone marrow synoptic reporting and elements of the report that provided data or information relevant to 1 or more key questions
3. English language articles of any study design

4. Studies from the years of 2002 to 2012

Exclusion Criteria

1. Noncomparative studies
2. Studies that address conditions outside of this list:
    a. *Neoplastic*: Multiple myeloma, amyloidosis, acute myeloid leukemia/acute lymphoblastic leukemia, chronic myelogenous leukemia, primary myelofibrosis, myeloproliferative neoplasms, myelodysplastic syndromes-clinical terms (e.g., low risk, high risk, World Health Organization [WHO]-refractory anemias), myelodysplastic/myeloproliferative neoplasms, Hodgkin lymphoma, non-Hodgkin lymphoma (NHL), chronic lymphocytic leukemia (CLL)
    b. *Nonneoplastic*: Anemia of chronic inflammation, parvovirus B19, iron deficiency anemia, vitamin B12 deficiency, folate deficiency, Paget disease of the bone, idiopathic immune thrombocytopenia, aplastic anemia (AA)
3. Studies that do not address reporting or factors that aid in reporting: text, font, order of elements, optimal presentation of data, document design, ease of use, clarity, error reduction (accuracy), minimizing incomplete reports, other important aspects of synoptic reporting
4. Studies that do not address morphologic descriptors, flow cytometry, fluorescence in situ hybridization (FISH) cytogenetics, molecular studies, other important ancillary studies
5. Editorials, letters, commentaries, invited opinions, or articles that did not address any key question were also excluded

Results

Of the 1,731 unique studies identified in the systematic review, 103 were selected for inclusion. These included 102 published peer-reviewed articles and 1 meeting abstract. Among the extracted documents, 8 articles did not meet minimum quality standards, presented incomplete data or data that were not in usable formats, or included only information based on expert opinion. These articles were not included in analyses or narrative summaries. The 95 remaining articles underwent data extraction and qualitative analysis.

For further details on the literature search, see the SDC (see the "Availability of Companion Documents" field).

## Number of Source Documents

A total of 95 articles were included for data extraction and qualitative analysis. See Figure 1 in the supplemental digital content (SDC) (see the "Availability of Companion Documents" field) for a flow diagram of the literature review results.

## Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

## Rating Scheme for the Strength of the Evidence

Grades for Strength of Evidence*

| Designation | Description | Quality of Evidence |
|---|---|---|
| Convincing | High confidence that available evidence reflects true effect. Further research is very unlikely to change the confidence in the estimate of effect. | High/intermediate quality evidence |
| Adequate | Moderate confidence that available evidence reflects true effect. Further research is likely to have an important effect on the confidence in the estimate of effect and may change the estimate. | Intermediate/low quality of evidence |
| Inadequate | Little confidence that available evidence reflects true effect. Further research is very likely to have an important effect on the confidence in the estimate of effect and is likely to change the estimate. | Low/insufficient evidence; expert panel uses formal consensus process to reach recommendation |
| Insufficient | Evidence is insufficient to discern net effect. Any estimate of effect is very uncertain. | Insufficient evidence; expert panel uses formal consensus process to reach recommendation |

*Adapted by permission from BMJ Publishing Group Limited. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. Guyatt GH, et al;

## Methods Used to Analyze the Evidence

Systematic Review with Evidence Tables

## Description of the Methods Used to Analyze the Evidence

Data Extraction and Management

The data elements from an included article/document were extracted by one reviewer into standard data formats and tables developed using systematic review database software (DistillerSR, Evidence Partners Inc., Ottawa, Canada); a second reviewer confirmed accuracy and completeness. Any discrepancies in data extraction were resolved by discussion. A bibliographic database was established in EndNote (Thomson Reuters, Carlsbad, CA) to track all literature identified and reviewed during the study.

Quality Assessment

An assessment of the quality of the evidence (risk of bias assessment) was performed for all retained studies following application of the inclusion and exclusion criteria by a contracted methodologist. Using this method, studies deemed to be of low quality were not excluded from the systematic review but were retained and their methodological strengths and weaknesses were discussed where relevant. Studies were assessed by confirming the presence of items related to both internal and external validity, which are all associated with methodological rigor and a decrease in the risk of bias. (Refer to the supplemental digital content [SDC] [see the "Availability of Companion Documents" field] for items relating to internal and external validity.) The quality assessment of the studies was performed by determining the risk of bias by assessing key indicators, based on study design, against known criteria.

For strength of the evidence, the panel considered the level of evidence, its quantity, and the quality of included studies. The level of evidence was based on the study design as follows:

- Level I was evidence from systematic reviews or clinical practice guidelines of appropriate level II studies
- Level II was evidence from good-quality, randomized, controlled trials
- Level III was evidence from low-quality comparative studies
- Level IV was evidence from studies without a comparator (see also Table 1 of the original guideline document)

In general, evidence from levels I and II is considered most appropriate for answering clinical questions, but in the absence of such high-quality evidence, the panel considered data from lower-quality studies. The quantity of evidence refers to the number of studies and the number of cases included for each outcome in the recommendation. The quality of studies reflects how well the studies were designed to eliminate bias and threats to validity.

The appropriateness of the study design and data collected, the relevance and clarity of the findings, and the adequacy of the conclusions were evaluated. Each study was assessed individually (refer to the SDC for individual assessments and results) and then summarized by study type. Components such as generalizability and applicability were also considered when determining the strength of evidence. A summary of the overall quality of the evidence was given after considering the evidence in totality. Ultimately, the designation (i.e., rating or grade) of the strength of evidence is a judgment by the expert panel of their level of confidence that the evidence from the studies informing the recommendations reflects true effect. See the "Rating Scheme for the Strength of the Evidence" field for a description of the grades for strength of evidence.

## Methods Used to Formulate the Recommendations

Expert Consensus (Nominal Group Technique)

## Description of Methods Used to Formulate the Recommendations

Panel Composition

The College of American Pathologists (CAP) Pathology and Laboratory Quality Center (the Center) convened an expert panel (EP) consisting of pathologists, a hematologist/oncologist, and a methodologist consultant to develop an evidence-based guideline to formalize the basic components

of a synoptic report for hematologic neoplasms. CAP approved the appointment of the project chair and panel members. The EP members performed the systematic evidence review. An advisory panel (AP) of pathologists, a hematologist/oncologist, and a molecular biologist also helped in the development of the guideline. The role of the AP members was to provide guidance and feedback on the key questions for the literature search, vet the draft guideline statements prior to the public comment period, and to review and provide feedback for the manuscript and supplemental digital content (SDC).

Assessing the Strength of Recommendations

Development of recommendations required that the panel review the identified evidence and make a series of key judgments. Grades for strength of recommendations were developed by the CAP Center and are described in the "Rating Scheme for the Strength of the Recommendations" field.

Results

The expert panel met 21 times through teleconference webinars from February 2, 2012, through March 31, 2015. Additional work was completed via electronic mail. The panel met in person on November 2, 2013, to review evidence to date and to draft recommendations. An open comment period was held from April 21, 2014, through May 19, 2014, on the CAP Web site. Ten draft recommendations and 2 demographic questions were posted for peer review.

*Agree* and *disagree* responses were captured for every proposed recommendation. The Web site also received 178 written comments. All 10 draft recommendations achieved more than 80% agreement. Each expert panel member was assigned 3 pages of comments to review and summarize. After consideration of the comments, 2 draft recommendations were maintained with the original language; 6 were revised, and 2 draft recommendations were combined into one for 9 final recommendations. Resolution of all changes was obtained by unanimous consensus of the panel members using nominal group technique (rounds of teleconference webinars, email discussions, and multiple, edited recommendations). Final expert panel recommendations were approved by a formal vote. The panel considered laboratory efficiency and feasibility throughout the entire process although neither cost nor cost-effectiveness analyses were performed.

A detailed description of the methods and systematic review used for this guideline can be found in the SDC (see the "Availability of Companion Documents" field).

## Rating Scheme for the Strength of the Recommendations

Grades for Strength of Recommendations*

| Designation | Recommendation | Rationale |
|---|---|---|
| Strong Recommendation | Recommend for or against a particular bone marrow synoptic reporting practice (can include must or should) | Supported by convincing (high) or adequate(intermediate)quality of evidence and clear benefit that outweighs any harms |
| Recommendation | Recommend for or against a particular bone marrow synoptic reporting practice (can include should or may) | Some limitations in quality of evidence (adequate [intermediate] or inadequate [low]), balance of benefits and harms, values, or costs, but panel concludes that there is sufficient evidence and/or benefit to inform a recommendation |
| Expert Consensus Opinion | Recommend for or against a particular bone marrow synoptic reporting practice (can include should or may) | Serious limitations in quality of evidence (inadequate[low] or insufficient), balance of benefits and harms, values, or costs, but panel consensus is that a statement is necessary |
| No Recommendation | No recommendation for or against a particular bone marrow synoptic reporting practice | Insufficient evidence or agreement of the balance of benefits and harms, values, or costs to provide a recommendation |

**Derived from*: Guyatt GH, Oxman AD, Vist GE, et al; GRADE Working Group. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. BMJ. 2008;336(7650):924–926.

## Cost Analysis

The panel considered laboratory efficiency and feasibility throughout the entire process although neither cost nor cost-effectiveness analyses were

performed.

### Method of Guideline Validation

External Peer Review

Internal Peer Review

### Description of Method of Guideline Validation

A public comment period was held from April 21 through May 18, 2014 on the College of American Pathologists (CAP) Web site. An independent review panel, masked to the expert panel and vetted through the conflict of interest process, provided a review of the guideline and recommended approval by the CAP Council on Scientific Affairs.

## Evidence Supporting the Recommendations

### Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

## Benefits/Harms of Implementing the Guideline Recommendations

### Potential Benefits

- The benefits of implementing synoptic reports for bone marrow pathology reports include standardization of reporting, ease of comprehension, consistency, completeness/thoroughness, reproducibility, availability of data for downstream use, and the ability for cross-institutional comparable reporting. Ultimately the expert panel believes that these factors will improve the overall quality of patient care.
- Incorporation of clinical and ancillary information represents good medical practice and further promotes the concept of a diagnostic management team as the optimal approach to patient care by helping to reach a clinicopathologic diagnosis relevant for treatment and outcome.
- Including relevant clinical and laboratory information results in the completeness of the report and aids the pathologist in making a definitive diagnosis.

Refer to the original guideline document and supplemental digital content (SDC) for benefits of specific recommendations.

### Potential Harms

- The cost and time involved in creating/implementing synoptic reporting systems might pose a challenge for some institutions. Nonetheless, the panel concludes that the balance between the desirable and undesirable effects is in favor of synoptic reporting.
- While there might be increased costs in adding critical ancillary data to the synoptic report, the costs that might incur were deemed to be small relative to the net benefits of the information provided. The expert panel also acknowledges that timeliness in reporting might be delayed.
- As a result of standardizing the synoptic report, one might experience inconvenience in transcribing the report or a lack of autonomy. The expert panel believes that the value of standardization outweighs these inconveniences.

## Qualifying Statements

### Qualifying Statements

- The College of American Pathologists (CAP) developed the Pathology and Laboratory Quality Center as a forum to create and maintain evidence-based practice guidelines and consensus statements. Practice guidelines and consensus statements reflect the best available evidence and expert consensus supported in practice. They are intended to assist physicians and patients in clinical decision-making and to identify questions and settings for further research. With the rapid flow of scientific information, new evidence may emerge between the time a practice guideline or consensus statement is developed and when it is published or read. Guidelines and statements are not continually updated and may not reflect the most recent evidence. Guidelines and statements address only the topics specifically identified therein and are not applicable to other interventions, diseases, or stages of diseases. Furthermore, guidelines and consensus statements cannot account for individual variation among patients and cannot be considered inclusive of all proper methods of care or exclusive of other treatments. It is the responsibility of the treating physician or other health care provider, relying on independent experience and knowledge, to determine the best course of treatment for the patient. Accordingly, adherence to any practice guideline or consensus statement is voluntary, with the ultimate determination regarding its application to be made by the physician in light of each patient's individual circumstances and preferences. The CAP makes no warranty, express or implied, regarding guidelines and statements and specifically exclude any warranties of merchantability and fitness for a particular use or purpose. The CAP assumes no responsibility for any injury or damage to persons or property arising out of or related to any use of this statement or for any errors or omissions.
- There is an absence of recommendations pertaining to the quality of the primary bone marrow specimen. Although a high-quality specimen is desirable for optimal diagnostic workup, the minimum requirements depend on clinical circumstances and diagnostic needs. Because high-level evidence is not readily available for all scenarios, this was considered out of the scope for formal evidence-based recommendations at this time. The reader is referred to the CAP Cancer Protocols and existing guidelines pertaining to specimen quality.

# Implementation of the Guideline

## Description of Implementation Strategy

Dissemination Plans

The College of American Pathologists (CAP) plans to host a Bone Marrow Synoptic Reporting resource page which will include a link to the manuscript and supplement; a summary of the recommendations, a teaching PowerPoint and a frequently asked question (FAQ) document. The guideline will be promoted and presented at various society meetings.

## Implementation Tools

Quick Reference Guides/Physician Guides

Resources

Slide Presentation

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

# Institute of Medicine (IOM) National Healthcare Quality Report Categories

## IOM Care Need

Getting Better

Living with Illness

## IOM Domain

# Identifying Information and Availability

## Bibliographic Source(s)

Sever C, Abbott CL, de Baca ME, Khoury JD, Perkins SL, Reichard KK, Taylor A, Terebelo HR, Colasacco C, Rumble RB, Thomas NE. Bone marrow synoptic reporting for hematologic neoplasms: guideline from the College of American Pathologists Pathology and Laboratory Quality Center. Arch Pathol Lab Med. 2016 Sep;140(9):932-49. [76 references] PubMed

## Adaptation

Not applicable: The guideline was not adapted from another source.

## Date Released

2016 Sep

## Guideline Developer(s)

College of American Pathologists - Medical Specialty Society

## Source(s) of Funding

The College of American Pathologists (CAP) provided funding for the administration of the project; no industry funds were used in the development of the guideline. All panel members volunteered their time and were not compensated for their involvement, except the contracted methodologist.

## Guideline Committee

The College of American Pathologists (CAP) Pathology and Laboratory Quality Center Expert Panel

## Composition of Group That Authored the Guideline

*Expert Panel Members*: Cordelia Sever, MD, Department of Hematopathology, Pathology Associates of Albuquerque, Albuquerque, New Mexico; Charles L. Abbott, MD, Department of Pathology, Berkshire Medical Center, Pittsfield, Massachusetts; Monica E. de Baca, MD, Medical Laboratory Associates, Seattle, Washington; Joseph D. Khoury, MD, Department of Pathology, University of Texas MD Anderson Cancer Center, Houston; Sherrie L. Perkins, MD, PhD, Department of Pathology, University of Utah, Salt Lake City; Kaaren Kemp Reichard, MD, Department of Laboratory Medicine and Pathology, Mayo Clinic, Rochester, Minnesota; Ann Taylor, MD, Utah Pathology Services, Inc, Salt Lake City; Howard R. Terebelo, DO, Department of Hematology/Medical Oncology, Newland Medical Associates, Novi, Michigan; Carol Colasacco, MLIS, SCT(ASCP), Governance Department, College of American Pathologists, Northfield, Illinois; R. Bryan Rumble, MSc, Quality and Guidelines Department, American Society of Clinical Oncology, Alexandria, Virginia; Nicole E. Thomas, MPH, CT(ASCP), Surveys Department, College of American Pathologists, Northfield, Illinois

## Financial Disclosures/Conflicts of Interest

Before acceptance on the expert panel, potential members completed the College of American Pathologists (CAP) conflict of interest disclosure process, whose policy and form (in effect April 2010) requires disclosure of material financial interest in, or potential for benefit of significant value

from, the guideline's development or its recommendations from 12 months before through the time of publication. Potential members completed the conflict of interest disclosure form, listing any relationship that could be interpreted as constituting an actual, potential, or apparent conflict. Everyone was required to disclose conflicts before beginning and continuously throughout the project at each virtual and face-to-face meeting. Disclosed conflicts of the expert panel members are listed in the Appendix of the original guideline document. Please see the supplemental digital content (see the "Availability of Companion Documents" field) for full details on the conflict of interest policy.

## Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

## Guideline Availability

Available from the Archives of Pathology & Laboratory Medicine Journal Web site .

## Availability of Companion Documents

The following are available:

- Bone marrow synoptic reporting for hematologic neoplasms. Supplemental digital content. 2016 Mar. 56 p. Available from the College of American Pathologists (CAP) Web site .
- Bone marrow synoptic reporting for hematologic neoplasms. Summary of recommendations. 2016 Mar. 2 p. Available from the CAP Web site .
- Bone marrow synoptic reporting for hematologic neoplasms. Frequently asked questions. 2016 Mar. 2 p. Available from the CAP Web site .
- Bone marrow synoptic reporting for hematologic neoplasms: guideline from the College of American Pathologists Pathology and Laboratory Quality Center. Slide presentation. 2016 Mar. 34 p. Available from the CAP Web site .
- Bone marrow synoptic reporting for hematologic neoplasms. Infographic. 2016. 1 p. Available from the CAP Web site .

## Patient Resources

None available

## NGC Status

This NGC summary was completed by ECRI Institute on January 24, 2016. The information was verified by the guideline developer on February 23, 2017.

## Copyright Statement



# Disclaimer

## NGC Disclaimer

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